

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

9193 - 62-035883
STATE FILE NUMBERDO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED SEP 28 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in lb <u>20 YRS</u>	
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>416 S. KINGS HIGHWAY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HELEN YVONNE ANDREWS</u>		4. DATE OF DEATH Month Day Year <u>9 17 62</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1-31-1904</u>
9. AGE (last birthday) <u>58</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RECEPTIONIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOSPITAL</u>	
11. BIRTHPLACE (City and state or country) <u>ALTON ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>THOMAS N. ANDREWS</u>		13b. MOTHER'S MAIDEN NAME <u>GRACE DORLAQUE</u>	
14. NAME OF HUSBAND OR WIFE <u>None</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>978x</u>		17. INFORMANT <u>Ray J. Anderson 1705 Rodgers Ave</u> <u>Alton, ILL. MOIS.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock - Multiple Fractures of Ribs</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>of the Lung suffered when deceased jumped</u> <u>2 feet from 4th floor to ground below at Barnes Hosp.</u> <u>about 12:15 AM on Sept 10-1962 while suffering</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>a temporary mental breakdown</u> PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.) <u>See above</u>		20c. TIME OF INJURY Hour a.m. p.m. <u>9-10-62</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	
20f. CITY, TOWN, OR LOCATION <u>St. Louis</u>		COUNTY <u>MO</u>	
21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <u>Ray J. Anderson</u> (Degree or title) 22b. ADDRESS <u>1300 Clark</u> 22c. DATE SIGNED <u>9-24-62</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>9-15-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>UPPER ALTON</u>		23d. LOCATION (City, town, or county) <u>ALTON ILL.</u>	
24. FUNERAL DIRECTOR <u>MORROW-QUINN</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 24 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>			

USE BLACK INK

OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

~~or by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____



Licensed Embalmer No. 60133

P. O. Address Alton Ill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.